

## **Questions and Answers - Kentucky Medicaid Copayments      Update 9**

Native Americans, Alaskan Natives, pregnant women, children (under 18), and members in long term care will not pay copayments.

Shannon Turner, our Medicaid commissioner recently said, "Co-payments for prescription drugs and visits to doctors and hospitals could save about \$30 million from the Medicaid program's overall deficit.

Dr. Rick Voakes said he's frustrated because his Medicaid patients often visit an emergency room for minor ailments, such as a cold or ear infection. The result? Medicaid has to pay hundreds of dollars to the hospital instead of the \$27 it pays him for an office visit, Voakes told state Medicaid officials yesterday. "Our patients bypass us and go to the emergency room all the time," said Voakes, a pediatrician.

Mark Birdwhistell, our undersecretary for health said the state agreed with Voakes, and that part of its goal for overhauling Medicaid is to steer more people to primary care.

"Under federal rules, officials can't block people from going to an emergency room," he said, "but Medicaid could do more to encourage people to visit a doctor first." Undersecretary Birdwhistell added, "We've simply got a program in place that doesn't have sufficient controls and sufficient business practices."

**Questions and Answers - Kentucky Medicaid Copayments**  
General Questions, Concerns and Recommendations

**Update 9**

Q1: Please define a legitimate emergency service. Who makes this determination?

A1: We define a non-emergency service as one which fails to meet the federal criteria (established in 42 CFR 447.53) for an emergency service.

Q2: If a patient receives a screening only in the emergency room and is then referred to a physician's office, do they owe a copay?

A2: Copayments will be required for any non-emergent emergency room visit reimbursed by Kentucky Medicaid.

Q3: Can a member's copayment status change during the month?

A3: There are instances where copayment status could change. For example, pregnant women are exempt up to 60 days following delivery so on the 61st day following delivery (whatever day of the month that occurs) the person would lose exempt status and be subject to copayments. Anyone who falls out of an exempt category would be responsible for copayment on the date they lose exempt status.

Q4: If a patient receives multiple hospital services on the same day, will they owe multiple copayments? Example: Patient receives lab and x-ray in the am and is admitted as inpatient later that day.

A4: If an individual goes to an outpatient facility/ER and is directly sent to an inpatient hospital, we would consider it all part of one visit and would apply the one inpatient copayment and no outpatient copayment.

Q5: If a member does not pay the copayment at time of service can we write it off to bad debt at that point or do we have to go through a specific collections process prior to writing it off to bad debt?

A5: A provider shall collect a copayment from a member in an amount and for a service described in Section 2(1) and (2) of 907 KAR 1:604. A provider may collect the copayment at the time a service is provided or at a later date. A provider shall not refuse to provide a service if a member is unable to pay a required copayment. This provision shall not relieve a member of an obligation to pay a copayment; or prevent a provider from attempting to collect a copayment. If it is the routine business practice of a provider to terminate future services to an individual with uncollected debt, the provider may include uncollected copayments under this practice.

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Q6: Being an OB practice our OB patients begin coming once per month and the appointments get closer and closer together until they are coming for weekly visits. Do we charge OB patients the new \$2.00 co-pay each and every time they present to our office, or is this a one-time charge they we charge the patient at the beginning of their initial OB care?

A6: Pregnant women are not charged copayments.

Q7: The article mentions prescriptions and immediately thereafter states that co-pays do not apply to pregnant women and children under 19. Some in my office think this means that all OB patient visits are exempt while myself and others think this means that this exemption only applies to the prescription co-pays. Please clarify this for us.

A7: Copayments for doctor's office visits and prescription drugs do not apply to Medicaid members who are pregnant or 18 years of age and under.

Q8: Since our office is an OB office, we frequently send patients down to our hospital's outpatient department to have ultrasounds and/or other radiological services. Are patients required to pay that \$3.00 outpatient fee if they present to our office - pay their \$2.00 and then go to outpatient for an ultrasound?

A8: Copays do not apply to pregnant women.

Q9: Same scenario as above - patient is in our office - pays their \$2.00 co-pay but has an ultrasound performed in our office by a mobile ultrasound machine and mobile operator - do the patients have to pay the \$3.00 outpatient fee for this mobile ultrasound?

A9: Copays do not apply to pregnant women.

Q10: If a patient calls and we see them at the hospital as a private referral - is this considered an in-patient or out-patient service and if so, do we charge the patient respectively for the \$50 or \$3 co-pay?

A10: If the patient were pregnant, she would not be charged a copayment. If the patient is not pregnant, and is admitted to the hospital, s/he would be charged a \$50.00 copayment by the hospital, and that would be the extent of the patient's copayments for that hospital stay. If the patient is not admitted to the hospital, but is considered an outpatient, the patient would be charged a \$3.00 copayment.

Q11: Currently our office charges a \$20 lab and specimen-handling fee if lab services are performed. If we charge Medicaid patients this \$20 lab fee - do we also charge them the \$2 physician visit co-pay (total of \$22)?

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A11: If the patient is pregnant, the patient does not pay a copayment. If the patient were not pregnant, s/he would be charged the \$2.00 copayment for the office visit. If the patient is under 19, the patient is not charged a copayment.

Q12: Will our rural health payment rate be reduced by the amount of the co-pay? We also have a critical access hospital. Please explain how the co-pays will impact CAH payments.

A12: The rural health clinic is considered to be a physician's office. All hospitals, including CAH, are expected to collect a \$50.00 copayments for an inpatient admission, which will be deducted from the hospital's reimbursement.

Q13: Do Medicaid copayments apply to people 18 and older or people under 18?

A13: An individual is exempt from copayment if s/he is 18 years of age and under.

Q14: Federal law says that members cannot be denied service due to an inability to pay a copayment. How will members and providers be advised of that rule?

A14: If it is the routine business practice of a provider to terminate future services to an individual with uncollected debt, the provider may include uncollected copayments under this practice. A provider shall not waive a copayment obligation as imposed by the department for a member.

Q15: People who are sicker and need more care will have to pay more. Often, this means older people. Is there a limit on how much a person must pay per month or per year?

A15: Due to concerns raised at several public forums, Medicaid is currently considering the possibility of establishing a maximum amount that an individual may be charged within a certain period of time as a safety net for those with chronic conditions. This issue is currently under consideration by the Cabinet.

Q16: A study reported in the *Journal of the American Medical Association* showed an increase in "adverse incidents" when new drug co-payments were imposed on welfare adults. With its new information systems, can Kentucky watch for increases in hospitalization and ER visits for at-risk groups here?

A16: The department currently has the capability to track these trends. Medicaid will also be surveying providers about the implementation of the new copayments.

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Q17: Some very low-income people are included in the optional categories. Both K-TAP (Kentucky Transitional Assistance Program) caretakers and some spend-down members have income *below* the federal poverty level. Why are we imposing higher drug copayments on them?

A17: Kentucky Medicaid must first consider the needs of the people it is mandated to serve. In light of our budget shortfall, Kentucky Medicaid must consider all options that will help reduce the deficit without threatening essential services.

Q18: One rationale offered for co-payments is that they make people “stop and think” about whether they really need care, leading to cost-savings from lower utilization. But don’t doctors in fact order all non-emergency inpatient hospital stays? Do we really want to impose a \$50 cost barrier to receiving the care that a doctor orders?

A18: The copay is not intended as a deterrent to receiving proper and necessary healthcare. Copayments are, however, cause for all parties to “stop and think,” not only the member, but also the provider, about necessary and unnecessary procedures or choosing the most appropriate setting for the type of care needed. Providers as well as members must develop a more proactive approach and become informed consumers of health care. Becoming aware of the true cost of health care is an important step in becoming an informed consumer.

Q19: If the patients are paying the \$2 physician’s office visit co-pay - how does this help your \$675 million shortfall since the money is coming to us and not to Medicaid? Will we receive less reimbursement if we do not receive the \$2 co-pay? Or will our reimbursements stay the same?

A19: The copay, or cost sharing, initiative is not intended solely to be a cost avoidance measure. We hope to impact the culture of Kentucky Medicaid by encouraging responsible use of available services. Kentucky Medicaid hopes to involve the Medicaid member in the vision of Medicaid by allowing the member to become an active participant in our program, rather than a passive consumer of services.

Q20: Do copayments apply to community mental health center services?

A20: No.

Q21: Do copayments apply to the qualified Medicaid beneficiary (QMB)? Or, for that matter, any crossover claims (dual eligibles)?

A21: QMB and dual eligibles are exempt from copayments.

Q22: What about ARNP (advanced registered nurse practitioner) claims? Do we apply copayments to their services?

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A22: Yes, we apply the standard physician office copayment to services provided by the ARNP.

Q23: Do we charge a copayment for physical therapy?

A23: Copayments would apply to physical therapy. The amount assessed would depend on where the service is provided. Currently, Kentucky Medicaid reimburses for physical therapy on an inpatient/outpatient basis. Therefore, the member would be charged a \$3.00 copayment for outpatient physical therapy. The hospital would collect the \$50.00 copayment for the entire hospital stay.

Q24: Does an assisting physician charge a copayment for inpatient surgery?

A24: The inpatient copayment is not deducted from the physician's reimbursement. It is deducted from the hospital reimbursement.

Q25: Do Passport members pay a copayment?

A25: Passport members will pay the copayments they have always paid, until they are notified otherwise.

Q26: How do I handle a KenPAC member's copayment? Are they any different?

A26: No. They are not considered distinct in matters related to copayments.

Q27: If a patient receives multiple hospital services on the same day, will they owe multiple copayments? Example: Patient receives lab and x-ray in the am and is admitted as inpatient later that day.

A27: Copayment will be assessed only once per date of service for each recipient/provider combination. In other words, if a recipient receives more than one service on a particular date from the same provider, only one copayment will be assessed for that date of service. If a recipient sees two different providers on the same date, copayment will be assessed for both visits. In cases where a recipient receives services from a clinic, copayment will be deducted only once per date, per clinic, even though the recipient may have received services from different providers within the clinic.

Q28: Do psychiatric hospitals collect an inpatient copayment?

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A28: No. 42 CFR 447.53 addresses cost-sharing exclusions for “Institutionalized individuals” in 42 CFR 447.53(b)(3). Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution if the individual is required (pursuant to 435.725, 435.733, 435.832, 436.832), as a condition of receiving services in the institution, to spend all but a minimal amount of his income required for personal needs, for medical care costs are excluded from cost sharing.

Q29: A provider asked how they are to determine if a member falls into the classification of Native Americans, Alaskan Americans or Pacific Islanders. Provider stated: "If we ask the member, they risk offending them if they are not in one of the classifications."

A29: The member will declare the exemption, if he or she wishes to be exempt from the copayment. The provider does not have an obligation to inquire, nor does the provider have an obligation to determine if the member is truthful. The member, however, should know that if they are not being truthful they risk being charged with fraud. If the provider believes that fraud is being committed with regard to this exemption, the provider should report this to the Kentucky Department for Medicaid Services.

Q30: Will Medicaid members enrolled in Hospice be required to pay copays?

A30: Medicaid members enrolled in Hospice are exempt from paying copayments.

Q31: I had a provider call and ask if they can refuse to see a patient if it is for routine care & the patient does not have the co-pay.

A31: If it is the routine business practice of a provider to terminate future services to an individual with uncollected debt, the provider may include uncollected copayments under this practice.

Q32: We have been receiving numerous calls from recipients regarding the optional eligibility groups for the new copays. Could you shed some light on this and let us know exactly what copays are going to be charged and when?

A32: The cabinet, as a result of holding its public forums on the issue of copayments, has decided to take the issue of copayments for optional eligibility groups under advisement and will notify the public of its decisions at a later date.

Q33: Physicians in physician offices have the capacity to enter a CPT code denoting an individual should be admitted to an inpatient hospital. Should the physician office then collect the inpatient hospital admission copay of \$50?

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A33: An inpatient hospital admission copay should only be collected by the hospital itself. The hospital is the provider receiving the recipient on an inpatient basis rather than the physician and in some cases the recipient who is referred to a hospital does not actually enter a hospital.

Q34: Are dental services assessed a copayment?

A34: Yes. Dental service providers have assessed a copayment since 2003 and will continue to do so. The current copayment regulations are not related to the assessment of copayments for dental services, however.

Q35: Are "lab only" services assessed a copayment?

A35: Yes.

Q36: I would feel better if I could verify that a patient is Native American, rather than just taking their word for it. How can I go about doing that?

A36: "Verifying Native American status is discussed in §3212.6 of the State Medicaid Manual as well as in §104.62 and §104.63 of the proposed regulations published by the Department of Justice on August 4, 1998 at 63 *Federal Register* 41685. This material indicates that waiver of cost-sharing requirements shall be granted upon "acceptable documentation". Acceptable documentation includes:

1. An American Indian or Alaskan Native enrollment document from a federally recognized tribe;
2. A Certificate Degree of Indian Blood (CDIB) from the Bureau of Indian Affairs; or
3. A letter of Indian Heritage from an Indian Health Service supported facility operating in the state."

Q37: Will Medicaid be posting these Questions and Answers on the Internet?

A37: Yes. We are currently working with our Webmaster to post these Questions and Answers and to ensure timely updates.

Q38: Do physician assistant visits require copayments?

A38: Yes.

Q39: Does the facility collect the \$3.00 copayment for outpatient service, or does the physician collect it?

A39: The facility will collect the \$3.00 copayment for outpatient services, as the \$3.00 is deducted from the hospital reimbursement.

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Q40: If a patient comes in for a lab only visit, do they have to pay the co-pay?

A40: Yes.

Q41: If a patient comes in for an injection only, do they have to pay the co-pay?

A41: Yes.

Q42: If the KY Health net shows a copay indicator of “N” should the patient be charged the copay?

A42: No.

Q43: Is the co-pay indicator information on the KY Health Net accurate?

A43: To the best of our knowledge, the information on KY Health is accurate.

Q44: If the patient has Medicare or Commercial Insurance should they be charged the copay?

A44: The member should not be assessed a Medicaid copayment, if they are not using Medicaid at the time of service.

Q45: There is a discrepancy in the age limits between questions/answers 7 and 13. One says age 18 and the other one says age 19. Which is correct?

A45: “Under 19” and “18 years of age and under” are equivalent; thus, no discrepancy exists.

Q46: In regards to question 29, I had heard that people who are Pacific Islanders, Native Americans or Alaskan Natives would be required to tell the caseworker this when they apply for Medicaid. That way their card would reflect that they do not pay a co-pay. Is this correct?

A46: It would make good sense for DCBS to gather this information at the applications stage. I would endorse any of the methods described in the Q&A document as a valid method of declaring exempt status. As these issues arise, however, Medicaid will address them. Please notify your manager, of any situations that occur involving the verification of one of these exempt groups.

Q47: Are Pacific Islanders exempt from co-pay? Some places have them listed and some places don't. If they are exempt, how would we verify this?

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A47: Yes. If these issues arise, and further clarification is needed, Medicaid will address them. Please notify your manager of any situations that occur involving the verification of a Pacific Islander.

Q48: Is there a Website I can go to, to get answers to my questions about copayments?

A48: Yes. The DMS Website address is <http://chfs.ky.gov/dms/default.htm>, You can locate the Q&A by clicking <http://chfs.ky.gov/NR/rdonlyres/68A7A8DAA63B4B729E7792AF42835858/0/QACopayments8.pdf>.

Q49: If a KenPAC member does not pay the copayment, can the physician deny service?

A49: Yes. The member would have to contact Medicaid and ask to be reassigned another physician.

INFORMATION: This is the link to the DMS KYHealth-Net website. It can be accessed by clicking on the KYHealth-Net box on the left hand side. <http://www.chfs.ky.gov/dms/>

This website is for Medicaid providers who wish to verify member eligibility and to check on their claims submission. If the provider does not have access to this website, they can contact EDI Help desk at Unysis. Contact information is on the website.